Metro Nashville
Pensioner Benefit Handbook

Metro Nashville

YOU SERVE METRO. WE SERVE YOU.

Contents

Introduction

Accessing your Benefits Information

Visit Human Resources on the web at www.nashville.gov to get answers regarding your benefit questions and to access insurance carriers, summary plan descriptions, online health and retirement tools as well as the latest news concerning your benefits.

This Document…

This document presents an overview of Metro benefits and is intended for informational purposes only. If there is a difference between this overview and the official plan documents or provider contracts, the official plan documents and provider contracts will govern. For more detailed information, please refer to Metro Human Resources' website or your insurance carrier's website.

HIPAA Compliance

The Health Insurance Portability and Accountability Act (HIPAA) requires that your health insurance plan limit the release of your health information to the minimum necessary required for your care, or as outlined in the Metro Human Resources – Notice of Privacy Practice found on Human Resources' website at www.nashville.gov. If you have questions about your claims please contact your insurance carrier first. If, after contacting the carrier, you need Metro to assist you with any claim issues, you may be required to provide Metro with written authorization to release information related to your claim.

Disclosure of Grandfather Status under the Patient Protection and Affordable Care Act

Metro Nashville Government believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on essential benefits. Annual lifetime limits continue to apply to custom built shoes and travel expenses for organ transplants. Metro Nashville Government has determined that these are not essential benefits for purposes of the Affordable Care Act.

Questions regarding which protections apply and which protections do not apply to a grandfathered plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at Metro Human Resources (615) 862-6640. You may also contact the U.S. Department of Health and Human Services at *www.healthreform.gov*.

2016 IMPORTANT CONTACTS

PLAN	CARRIER	WEBSITE	PHONE
Medical	Humana Medicare Advantage	humana.com	(866) 396-8810
	BlueCross BlueShield (BCBS) PPO	bcbst.com/members/metro-gov	(800) 367-7790
	Cigna Choice Fund	If enrolled: mycigna.com If not yet enrolled: mycignaplans.com (ID: metro2016; password: cigna)	(800) 244-6224 (800) 401-4041
Dental	BlueCross BlueShield of TN	bcbst.com/members/metro-gov/dental	(800) 367-7790
Vision	NVA	e-nva.com (user name: metro; password: vision1)	(800) 672-7723
Life Insurance	Prudential	prudential.com/gi	(877) 232-3619
General	Metro Human Resources	nashville.gov/human-resources	(615) 862-6700

2016 BENEFIT PLAN RATES

MEDICAL	MONTHLY RATE		
Coverage Level	Humana Medicare Advantage	BCBS PPO	Cigna Choice Fund*
Single (without Medicare A & B)	N/A	$173.00	$171.00
Family (none with Medicare A & B)	N/A	$436.00	$434.00
Pensioner Only (with Medicare A & B)	$75.30	$95.00	$107.00
Pensioner + Spouse (both with Medicare A & B)	$150.60	$190.00	$214.00
Pensioner (with Medicare A & B) + Spouse (without Medicare A & B)	N/A	$268.00	$278.00
Pensioner (without Medicare A & B) + Spouse (with Medicare A & B)	N/A	$268.00	$278.00
Pensioner (with Medicare A & B) + Child(ren) (with or without Medicare A & B)	N/A	$190.00	$214.00
Pensioner, Spouse and Child(ren) (all with Medicare A & B)	N/A	$285.00	$321.00
Three Family Members Covered (two of them with Medicare A & B)	N/A	$363.00	$385.00

DENTAL	Flexible Plan	Limited Plan
Single	Metro provides single dental coverage at no cost to you	
Family	$37.72	$37.72
VISION	Basic Plan	Enhanced Plan
Single	$3.04	$4.80
Family	$9.30	$15.34

* Pensioners with Medicare A & B are not eligible to receive the Health Reimbursement Account (HRA) Fund.

Benefits at a Glance

Eligible Metro pensioners have the option to enroll in the following benefit plans at retirement or disability. You may make changes to your benefits within 60 days of an eligible change in status or you may change plans during Annual Enrollment. Dependents may only be added within 60 days of an eligible change in status.

Core Benefit Options and Highlights	
Medical	Plan Options: • Humana Medicare Advantage – a Medicare advantage plan for members with Medicare Parts A and B • BCBS PPO – 80/20% coinsurance plan with copays • CIGNA Choice Fund – HRA funded by Metro (for pensioners without Medicare Parts A and B) to pay first dollar claims before you pay a deductible
Dental	Plan Options – both share the same network of dentists: • Flexible – $1,000 annual benefit max with in- and out-of-network dentists • Limited – schedule of benefits with in-network dentists only
Basic Life	Automatically enroll for $10,000 basic term life

Optional Benefits and Highlights	
Vision	Plan Options: • Basic – eye exam every 12 months; glasses or contacts every 24 months • Enhanced – eye exam every 12 months; glasses or contacts every 12 months; 100% coverage for standard progressives and polycarbonates

Enrollment & Eligibility

Eligible Pensioners and Coverage Effective Date

Metro pensioners eligible for an Early or Normal service pension when their employment ends are eligible to enroll in benefits. Coverage is effective the day your pension benefit becomes effective.

Your coverage will end when your pension ends or when you die. Your spouse/domestic partner and dependent children may be eligible to continue their coverage if they receive a survivor pension benefit.

Opting Out of Coverage

Disability, Service and Survivor pensioners who can enroll in other medical and/or dental coverage may opt out of Metro's insurance coverage. Pensioners who wish to preserve their future right to reenroll in Metro's plans, must provide proof of other non-Medicare coverage – either an insurance card in the pensioner's name or a letter from the other insurance company. If you opt out and later lose your non-Metro medical or dental coverage or have an eligible change in status, you have 60 calendar days to re-enroll in Metro's medical or dental plan.

Additionally, Service pensioners and Survivors may opt out of Metro's insurance coverage at any time <u>without</u> proof of other coverage; but by doing so, will never be allowed to reenroll in Metro's plans.

Coverage Levels

You may choose from different levels of coverage based on your Medicare status and the status of your dependents. For a list of coverage levels available, please refer to the Benefit Plan Rates for Pensioners chart on page 5.

Eligible Dependents

You may enroll your eligible dependents in your medical, dental and vision insurance at the time you go on pension or within 60 days of an eligible change in status. Eligible dependents include your:

- Legally recognized spouse, while not divorced or legally separated)
- domestic partner (documentation will be required proving you've shared a primary residence for the last 365 days and you are financially interdependent upon one another); and
- dependent child(ren) from birth up to age 26 if he/she:
  - is your or your domestic partner's child by birth, legal adoption, legal guardianship or court order who may or may not reside in your home the majority of the time on an annual basis;
  - is your stepchild;
  - is a foster child living in your residence in accordance with a "Foster Care Placement" which means and is defined as the supervised adoption period prior to final adoption, as approved by a court of competent jurisdiction;

- dependent child(ren) over age 26, if coverage under Metro benefits has been continuous and he/she is incapable of self-sustaining employment by reason of mental retardation or physical handicap (contact Human Resources for details).

The following are not eligible for Metro benefits:

- foster children (placed in the home for care, but not adoption);
- ex-spouses or ex-domestic partners, except as allowed under COBRA; or
- parents of the pensioner or spouse/domestic partner.

Eligible Changes in Status

The benefits you choose at the time of your pension or during Annual Enrollment remain in effect for the entire plan year unless you have an eligible change in status such as:

- Marriage or divorce;
- Birth or adoption of a child;
- Change in job status for you or your dependent;
- Loss of coverage for you or your dependent; or
- Death of a covered eligible dependent.

You must notify Metro Human Resources and provide documentation within 60 calendar days of an eligible change in status to make a change in your benefit elections. Not notifying Metro Human Resources timely may prevent you from adding a dependent or may require you to pay family premiums for the remainder of the plan year when a dependent is no longer eligible.

For a complete list of eligible changes in status and instructions on changing your benefit elections, contact Metro Human Resources.

Metro pensioners may NOT add dependents during Annual Enrollment and may only add dependents within 60 days of an eligible change in status.

Medicare Coverage

If you become eligible for Medicare while you are still actively employed by Metro, you are not required by Metro to take Medicare Parts A and B. However, **once you are retired from Metro, you and your dependents are required to enroll in Medicare Parts A and B as soon as you first become eligible – regardless of other coverage you have or your employment status outside of Metro**. If you do not enroll in Parts A and B, medical claims will be coordinated as if you did have Medicare.

COBRA Continuation Coverage

If you or your dependents lose your eligibility for health care coverage for certain reasons, you will be allowed to continue coverage for a certain period of time under COBRA provisions. Your dependents have the right to continue coverage even if you do not elect to continue your own coverage. Metro does not pay for coverage under COBRA; you or your dependent will pay 100% of the cost plus a 2% administration fee.

You or your dependents are eligible for COBRA continuation if coverage ends because:

- You die;
- You get divorced or legally separated; or

- Your dependent child becomes ineligible for coverage.

If you or your dependents qualify for COBRA, you will be mailed a packet with rate information and payment instructions from Metro's COBRA administrator.

Coordination of Benefits

Regardless of which medical plan you elect, you must be sure to notify your insurance carrier if your dependents receive health coverage outside of Metro's plan (for example, through your spouse/domestic partner's insurance plan at work or by qualifying for Medicare).

If your dependent has coverage elsewhere, a process called coordination of benefits (COB) comes into play. COB simply means that benefits are coordinated between your dependent's coverage under your Metro plan and another plan. This process ensures that benefit payments are not duplicated and helps hold down the rising cost of health insurance.

Women's Health Provisions

No matter which medical plan option you choose, your hospital coverage for childbirth will be for the same minimum number of days, as required by federal law.

- If your baby is delivered vaginally, you may stay in the hospital at least 48 hours (two days) after the birth;
- If you have a cesarean section, you may stay in the hospital at least 96 hours (four days) after the birth; or
- If the attending physician believes you need a longer stay, you may receive benefits for additional days if your doctor obtains pre-authorization from the insurance company. On the other hand, if you and your doctor agree that, in your case, the minimum number of days is not necessary, you may be released from the hospital earlier.

Under the Women's Health and Cancer Rights Act of 1998, all health plans that provide mastectomy coverage are also required to provide coverage for:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical (balanced) appearance; and
- prostheses (artificial replacements) and physical complications at all stages of the mastectomy, including lymphodemas.

Subrogation

If you or your dependent receives benefits under Metro's health plan as a result of an injury or illness caused by another person, Metro has the right to recover payment from that person and his/her insurer. This

"subrogation right" applies to all payments made by Metro's plan for related medical services.

You or your dependent may be asked to provide information and otherwise help in the recovery process. If you fail to do so, or if you settle a claim without the written consent of Metro's plan administrator, you will be responsible for paying any attorneys' fees and court costs incurred in the recovery process.

Your Medical Plans

Humana Medicare Advantage

The Humana plan is a Medicare Advantage Preferred Provider Organization (PPO). This is not a Medicare Supplement plan. Humana is only available to pensioners and their covered dependents that have both Medicare Part A and Part B coverage.

Humana has a network of providers; however, you are able to see any out-of-network provider who accepts Medicare and agrees to bill Humana.

Preventive Care

This plan provides each participant 100% preventive care coverage which includes pap smears, mammograms, pelvic exams, prostate cancer screening and bone mass measurement.

Pharmacy Benefits

Prescription drug coverage is provided by Humana and is available through most retail pharmacies and Humana's home delivery pharmacy. The generic drug copay is less than the copay of a brand name drug. A list of all participating pharmacies may be obtained by calling Humana or by visiting their website.

BlueCross BlueShield PPO

The BCBS PPO plan is an 80/20 coinsurance plan with copays that allow you the flexibility to select your physicians without referrals. After the annual out-of-pocket maximum has been met, you will continue to pay your copay, but your coinsurance level will be 100%. To receive the maximum benefits, you should use an in-network provider that participates in Network P. You may contact BCBS or visit their website for a list of in-network providers. If you choose to use an out-of-network provider, you will still receive benefits, but at a lower level (60/40) and you may be required to pay the entire bill up front and file a claim with BCBS for reimbursement.

Preventive Care

This plan provides each participant 100% preventive care coverage up to $750 of in-network claims, then coverage is at 80% in-network. This means that your annual physical will be covered at 100% up to $750 for each member covered under your plan with any expenses above $750 covered at 80% as long as you use an in-network provider.

Please note that wellness screenings, such as the annual well-woman visit, mammogram, men's PSA screening, and colonoscopy, will continue to be covered in-network at 80% and are

not considered a part of the annual preventive benefit.

Pharmacy Benefits

Prescription drug coverage is provided by BCBS and is available through most retail and home delivery pharmacies. If you and each of your covered dependents has Medicare Parts A and B, prescription coverage will be coordinated with Medicare Part D (please do not enroll in any other Part D plan). BCBS members may obtain a one month supply for the cost of one copay and up to a three month supply for the cost of two copays which may be filed at certain retail pharmacies or through home delivery and mail order programs. The generic drug copay is considerably less than the copay of a brand name drug.

If you take a maintenance prescription on a regular basis, you should talk with your doctor about writing your prescription so that you may take advantage of the two copays rather than three. A list of all participating pharmacies may be obtained by calling BCBS or by visiting their website.

CIGNA Choice Fund

Fund and Deductible

The CIGNA Choice Fund is a health reimbursement arrangement where traditional medical coverage is combined with a Fund of contributions made by Metro. Pensioners without Medicare Parts A and B are eligible for the Fund. Once a pensioner is eligible to receive Medicare Parts A and B, Metro will not provide the HRA Fund (a pensioner may keep any rollover funds due the following year).

The HRA Fund can be used to pay for eligible health care and pharmacy expenses during the plan year. CIGNA has negotiated discounts with providers in their Open Access Plus Network and to receive the maximum benefits you should select providers in this network. There are no copays with the CIGNA Choice Fund; the full cost of the negotiated discount is the amount that is owed to the provider. If you choose to use an out-of-network provider, you will still receive benefits, but at a lower level and you may be required to pay the entire bill up front and file a claim with CIGNA for reimbursement.

Any money you have remaining in your HRA Fund at the end of the plan year will roll over to the next plan year and lower the amount of your deductible for that year.

Once the Fund has been exhausted, there is a deductible that you must meet before the plan begins paying at the coinsurance level. When your annual out-of-pocket maximum has been met, you have 100% coverage for the remainder of the plan year.

If during the same year that your coverage becomes effective, you add a dependent as a result of an eligible change in status, the HRA Fund and deductible will be increased as if you had family coverage on your insurance effective date. If you change from family coverage to single coverage at any point during the year, the HRA Fund and

deductible will not be decreased or prorated.

Incentive Programs

You can earn incentive dollars that will be added to your Fund and thereby decrease your deductible by qualifying and participating in one of the incentive programs. These programs and incentives are available on an annual basis:

- Health Risk Assessment (online health questionnaire) – this questionnaire is short, simple and easy to use, and helps CIGNA provide you with a holistic view into your health risks and provides a personalized health profile.
  - $100 per person 18 and older upon completion ($200 maximum per family).
  - Available to employees, pensioners, dependents age 18 or older.

- Disease Management for Cardiac, Diabetes and Chronic Obstructive Pulmonary Disease (COPD)
  - $100 per person ($200 maximum per family and up to two family members can qualify for one program per year).
  - Active participation is defined as engaging in three (3) telephone sessions with a CIGNA Well Aware nurse.

- Tobacco Cessation Program
  - $50 per person ($200 maximum per family).
  - Active participation is defined as engaging in two (2) telephone sessions with a CIGNA coach within the 12 month duration of the program.

- Healthy Pregnancies, Healthy Babies℠
  - $150 if you enroll by the end of your first trimester, or
  - $75 if you enroll by the end of your second trimester.
  - Participation in the program is designed to help you and your baby stay healthy during your pregnancy. This program encourages you to get prenatal care early in your pregnancy. When you complete the program and after your baby is born, you will receive the incentive dollars.

Preventive Care

In-network preventative care services are covered at 100% and are not applied against the HRA Fund. Preventive services received from an out-of-network provider are covered at 70% and do reduce the dollars in your Fund.

Pharmacy Benefits

Prescription drug coverage is provided by CIGNA and is available through most pharmacies and by mail order. While you are in the Fund and deductible levels, you will pay the full price of the discounted cost of the generic or brand-name drug. Once you have moved into the coinsurance level, you will pay 10% of the discounted cost for generic drugs and 30% of the discounted cost for brand name drugs.

The pharmacy will determine the amount you owe, if any, for the prescription drug depending upon the fund balance in your HRA Fund and if you have met your deductible. If you have exhausted your fund but not yet

met the deductibe, you will pay the full price of the discounted cost of the drug at the time you pick up the drug.

A list of all participating pharmacies may be obtained by calling CIGNA or by visiting their website.

Your Dental Plans

Metro offers two dental plan options – either the Flexible or Limited plan and both are provided by BlueCross BlueShield. While both dental plans share the same DentalBlue network of dentists and the premiums are the same, each plan's benefit payment structure is different (see the Dental Plan Comparison Highlights).

The Flexible Plan gives you the flexiblility to go both in-network and out-of-network for care and pays a percentage of the charges. The Limited Plan only pays for in-network care and has a flat dollar copay for most services.

2016 MEDICAL

See Summary of Benefits and Coverages for more details.

	HUMANA MEDICARE ADVANTAGE	BCBS PPO		CIGNA CHOICE FUND	
	In-Network[1] (must have Medicare A & B)	In-Network (Blue Network P)	Out-of-Network[4]	In-Network (Open Access Plus)	Out-of-Network[4]
Health Reimbursement Account (Metro funded)[2]	N/A	N/A	N/A	$1,100/single; $2,200/family[2]	
Your Share of the Deductible	$0	$0	$200/single; $600/family	$450/single; $900/family	
Coinsurance Maximum	N/A	$1,000/single $2,000/family	$5,000/single $10,000/family	$700/single $1,400/family	$4,550/single $9,100/family
Annual Out-of-Pocket Maximum (deductible & coinsurance)	$1,000/individual	$1,000/single $2,000/family	$5,000/single $10,000/family	$1,150/single $2,300/family	$5,000/single $10,000/family
Medical Services					
After deductible, plan pays… (unless otherwise noted)					
Well Care/Preventive Care					
- Age 7 and older	100% (including pap smears, mammograms, pelvic exams, prostate exam, bone mass measurement)	100% up to $750, then 80%[5]	60%[5]	100%	70%
- Under age 7	N/A	80%	60%	100%	70%
Office Visits					
- Primary Care Physician[3]	100% after $10 copay	80% after $20 copay	60% after $20 copay	90%	70%
- Specialist	100% after $10 copay	80% after $30 copay	60% after $30 copay	90%	70%
In-office Procedures (surgery, consultation, allergy injections)	100% after $10 copay	80% after office visit copay	60% after office visit copay	90%	70%
Maternity					
- Prenatal Care	Covered as any other inpatient service	You pay $20 copay for initial visit	You pay $20 copay for initial visit	90%	70%
- Delivery	100%	80%	60%	90%	70%
Hospital	100% (unlimited days)	80%	60%	90%	70%
Emergency Room	100% after $50 copay; worldwide coverage (copay waived if admitted within 72 hours)	80% after $100 copay (copay waived if admitted)	60% after $100 copay (copay waived if admitted)	90%	90% (reduced to 70% if not true emergency)
Mental Health/Substance Abuse					
- Outpatient	100% after $10 copay	80% after $20 copay	60% after $20 copay	90%	70%
- Inpatient (pre-authorization required)	100% (190-day lifetime maximum in psychiatric hospital)	80%	60%	90%	70%
Routine Hearing Exam	100% after $10 copay	Covered if performed during preventive care physical exam			
Hearing Aid Benefit	$200 allowance every 2 years	Not covered			
Routine Vision Exam	100% after $10 copay	Covered if performed during preventive care physical exam			
Eyewear	$100 allowance per year	80% after cataract surgery	60% after cataract surgery	90% after cataract surgery	70% after cataract surgery
Dental care	$100 allowance per year	Not covered			
Prescription Drugs					
You pay…					
Up to 30-day supply (Humana) or 34-day supply (BCBS and Cigna)				After deductible:	
- Generic	$10 copay	$10 copay		10% of discounted cost	
- Brand	$20 copay	$30 copay		30% of discounted cost	
Up to 90-day supply (Humana) or 102-day supply (BCBS and Cigna)	2x above copays at Humana mail order pharmacy or 3x above copays at other participating retail pharmacies	2 times above copays through certain retail, home delivery and mail order pharmacies		Same as above through certain retail, home delivery and mail order pharmacies	

[1] Out-of-network care is covered at the same level as in-network care as long as provider accepts Medicare and agrees to bill Humana.

[2] Pensioners with Medicare A & B are not eligible to receive the Health Reimbursement Account (HRA) Fund and are immediately responsible for your share of the deductible.

[3] Primary Care Physicians include pediatricians, family and general practitioners, internists and OB/GYNs. Specialists include physicians highly trained in specific areas such as cardiology, dermatology, neurology, podiatry, oncology and specialized OB/GYNs.

[4] If you use an out-of-network provider and charges exceed the Maximum Allowable Charge (MAC), you will be responsible for the difference. In-network providers have agreed not to exceed MAC.

[5] Screening colonoscopies, mammograms, and prostate and PAP exams are covered at 80% after office visit copay (in-network) and 60% after office visit copay (out-of-network), but are not included in the $750 well-care benefit limit.

2016 DENTAL

	FLEXIBLE PLAN	LIMITED PLAN
	In-Network[1] (out-of-network coverage available)	In-Network Only[1] (no out-of-network coverage)
Annual Deductible	$75/person; $225/family	$0
Plan pays…		**See schedule of benefits for cost by service[2]**
Preventive/Diagnostic (2 exams/cleanings every 12 months, x-rays, sealants, fluoride)	100%; no deductible	100% for most services
Basic Restorative (fillings, extractions, oral surgery, root canals, periodontics)	80%; no deductible	100% for some services; you pay flat fee for other services
Major Restorative (crowns, bridges, dentures, implants)	50% after deductible	You pay flat fee for most services; implants not covered
Orthodontia (child and adult)	50% after annual deductible and one-time $100 orthodontia deductible	You pay flat fee for most services
Lifetime Orthodontia Maximum	$1,000/person	See schedule of benefits[2]
TMJ (temporomandibular joint) Treatment	50% after annual deductible and $100 annual TMJ deductible	Not covered
Lifetime TMJ Maximum	$750/person	N/A
Annual Benefit Maximum	$1,000/person (excludes orthodontia, TMJ)	N/A

[1] If there is no network provider within a 30-mile radius of your home, you may use an out-of-network provider and receive in-network benefits. Contact BCBS for instructions.

[2] View the Limited Plan schedule of benefits at **bcbst.com/members/metro-gov/dental**.

2016 VISION

	BASIC PLAN		ENHANCED PLAN	
	In-network	Out-of-network	In-network	Out-of-network
Deductible	$0		$0	
Exams	You pay $10 copay	Plan pays up to $45	You pay $10 copay	Plan pays up to $45
Lenses	You pay:	Plan pays:	You pay:	Plan pays:
- Single vision	$10 copay	Up to $40	$25 copay	Up to $40
- Bifocals	$10 copay	Up to $60	$25 copay	Up to $60
- Trifocal	$10 copay	Up to $80	$25 copay	Up to $80
- Lenticular	$10 copay	Up to $80	$25 copay	Up to $80
Lens options	Plan pays:		Plan pays:	
- Scratch-resistant coating	100%	Not covered	100%	Not covered
- Standard progressives	Not covered	Not covered	100%	Not covered
- Polycarbonate	Not covered	Not covered	100%	Not covered
Frames	Plan pays up to $130[1]	Plan pays up to $50	Plan pays up to $150[1]	Plan pays up to $50
Contacts (in lieu of frames/lenses)				
- Elective	Plan pays up to $125 after $10 copay[1]	Plan pays up to $125	Plan pays up to $140[1]	Plan pays up to $140
- Medically necessary	Plan pays 100%	Plan pays up to $210	Plan pays 100%	Plan pays up to $210
Covers…	One exam every **12** months; lenses, frames and contacts every **24** months		Exams, lenses, frames and contacts every **12** months	

[1] In many cases, NVA offers a discount on amounts exceeding retail allowance; ask your network provider.

Life Insurance

Basic Life

As a retired Metro employee, Metro provides you with $10,000 of basic term life insurance at no cost to you. Please refer to the life insurance policy located on Metro Human Resources' website for more information concerning your life insurance benefits.

Supplemental Life

Pensioners are not eligible to enroll in supplemental term life insurance. However, if you were previously enrolled as an active employee, you may elect to continue your supplemental term life coverage as a pensioner under an individual policy at the lesser of $20,000 or the amount that is in force prior to retirement (at least $10,000). The decision to continue your supplemental life coverage must be made at the time you are signing your pension application paperwork.

Waiver of Premium

If you are under the age of 60 and you become totally disabled according to the life insurance carrier's standards (not Metro's), you may apply for the waiver of premium for basic life, supplemental life and dependent life benefits and have your premiums waived as long as you continue to be disabled. You must apply within 12 months of the date you became disabled. If approved, your pre-retirement level of benefits may remain in effect until your age 70 as long as you continue to meet the life insurance carrier's criteria.

If you qualify for the waiver of premium, this is a free benefit to you. If you are denied for the waiver of premium benefit, you have 30 days from the date of the denial to appeal the insurance company's decision. If your appeal is denied, or you elect not to appeal the denial, you may convert to an individual policy; however, you must make written application and payment of premium within 31 days from the time the insurance company denies your waiver of premium application. To appeal or convert, you must contact the life insurance company directly.

Beneficiary

You may change your beneficiary at any time by completing a new form with Metro Human Resources. When you experience an eligible change in status (such as with a marriage, divorce or death) you should consider updating your beneficiary at that time. You may also name different beneficiaries to receive your basic life and supplemental life benefits.

Conversion & Portability Rights

At retirement, you have the option to convert to an individual life policy in $1,000 increments up to $40,000 (which is the difference between the $50,000 active employee amount and $10,000 pensioner benefit). You must make written application and payment of premium to the life insurance company within 31 days from the date you are notified by Metro. For more information, contact the life insurance company.

Pension Benefits

For information concerning pension benefits, please refer to the Disability Guide or the Retirement Guide located on Metro Human Resources' website at www.nashville.gov/human-resources.